STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	500 West McKinley Avenue Decatur, IL 62526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents right to dignified care for two of three residents (R1 and R3) reviewed for quality of care/abuse on the sample list of 15.Findings include:1. R1's current diagnoses list documents the following: Essential Hypertension; Chronic Obstructive Pulmonary Disease, unspecified; Bipolar Disorder with current episode depressed, mild or moderate severity, unspecified; Muscle wasting and atrophy, not elsewhere classified, multiple sites; Unsteadiness on feet; Lack of coordination; and History of falling.R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status score as nine out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R1 has limited range of motion of the bilateral upper extremities. The MDS further documents R1 is totally dependent for all activities of daily living except eating. R1 requires substantial to maximum assistance with toileting, has not ambulated during the look-back period, and uses a manual wheelchair requiring partial to moderate assistance once seated. R1 has had no behaviors toward self or others and no rejection of care.R1's current Physician Order Sheet documents Physical Therapy to continue three to five times per week for 41 days for therapeutic activities, therapeutic exercise, neuromuscular reeducation, gait training, and group therapy, with a start date of 12/18/25 and an end date of 01/28/26.The facility's January Concern Log - Year 2026 documents a grievance dated 01/14/26 as follows: Night Shift, Unit 1. Concern reported by Patient (R1). Name: Social Service Director (V4) / Business Office Manager (V18). Concern Type: Care - Staff Approach. Patient Name and Brief Description: (R1) wants to discharge home; stated she is tired of the mean CNA that works nights. She stated the CNA is rough with care. Concern Assigned to: Administrator (V1, Interim Administrator/Abuse Prevention Coordinator). Resolution Communication Method: Employee - Written Notice. Date Resolved: 01/14/26 (same day the grievance was reported).On 01/20/26 at 1:30 p.m., V4, Social Service Director (SSD), reviewed the grievance log with this surveyor. V4 stated R1 was upset and wanted to be discharged related to therapy. V4 stated, I reached out to her case manager (V7, Community Support Services Manager for the local county), and we all met. They came down to my office, and we were all sitting here talking to (R1). Therapy staff were going to pick her back up for therapy. She said, 'I just want to go home. I don't want to do it there.' This was the next day, on the 14th. She said it shouldn't have to take all this to go home and that it wasn't fair. I told her there were other programs I could look into and mentioned Starting Point. I told (V7) I knew she would assist (R1) with access in the community and help with resources. She said she didn't want to lose (V7's) assistance. I told her I would look into some options. She got mad. I'm going to be honest-I noticed bruises on her arms. I asked her what happened. It looked like she bumped the backs of both arms on something. She had been in the hospital on [DATE], and I asked if the bruises were from IV access. She said a night CNA-a (specific race) girl with pulled-back hair-was rough with her care.On 01/22/26 at 3:42 p.m., V8, Certified Nursing (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA), stated, I was suspended. All I know is I got a call last Friday and was told I was on administrative leave because (R1) made some kind of abuse allegation about me. I have taken care of her for almost a year. Her hall is the only hall I have ever worked on. She is one of the easiest residents to take care of. She is so sweet. I would never hurt any of my residents on purpose. I have racked my brain trying to figure out what upset her about my care. All I can think of is she has a bad rash between her legs, and when she urinates, it burns her rash. I had to be extra careful when providing perineal care. She said the last morning I got her up that the washcloth was too rough. Our washcloths are rough. She was urinating, and I tried to catch it with the washcloth before it got on her labia and upper inner thighs. That is when she said it was rough-she meant the washcloth. When I washed her, I was careful. She never said anything else about it. I always put a lot of barrier cream on the rash. The nurses apply nystatin powder all over her rash and in her brief. I got her dressed, and she never said anything. If she thought I was hurting her in any way, I would have left the room and gotten another CNA. I would have reported it myself if she accused me of being rough. I think it is important that all residents are treated right.On 01/27/26 at 10:30 a.m., V7, Local County Community Support Services Manager, confirmed she was present on 01/14/26 with R1 and V4. V7 stated R1 described a CNA with a ponytail who was rough when getting her up that morning. V7 stated R1 had small bruises on both forearms that appeared faded. R1 was unsure how they occurred but associated them with being transferred from bed to a standing position. V7 also stated R1 reported feeling a pull in her neck during the transfer. V7 stated R1 had been hospitalized a week prior for chest and neck pain and that this information was included in the complaint to ensure investigation. V7 stated R1 was afraid the CNA would be rough with her care again. Although R1 was not tearful, she was upset about therapy and expressed fear regarding the CNA's care. V4 acknowledged the allegation of rough care and stated it would be reported to the Administrator and investigated as possible abuse.2. R3's current Diagnoses sheet documents: Other Specified Postprocedural Status; Aftercare Following Joint Replacement Surgery.R3's current Physician Order Sheet (POS) documents a splint (sling) to the left arm, to be worn daily. The POS further documents, effective 01/21/26, continuation of Occupational Therapy three to five times per week for four weeks for activities of daily living retraining, therapeutic exercises, therapeutic activities, neurological reeducation, wheelchair management, manual therapy, and group therapy.R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 15 out of 15, indicating no cognitive impairment. The same MDS documents range of motion impairment of one upper extremity. The MDS further documents R3 requires substantial/maximal assistance with upper and lower body dressing, defined as the helper performing more than half the effort, including lifting or holding the trunk or limb.The facility's January Concern Log - Year 2026 documents a grievance dated 01/07/26 as follows: Night Shift, Unit 1. Concern reported by Patient (R3). Name: Social Service Director (V4). Concern Type: Care - Staff Approach. Patient Name and Brief Description: (R3), CNA on phone during care. Concern Assigned to: Social Service. Resolution Communication Method: Employee - Written Notice. Date Resolved: 01/07/26 (same day reported).On 01/20/26 at 1:55 p.m., V4 reviewed R3's grievance. V4 stated R3 reported the CNA was on her phone while providing care, was rude, and was rough with care. V4 identified the CNA as V11. V4 stated she contacted V11 on her personal cell phone and addressed the phone use. V4 stated she did not consider the situation abuse because she knew the CNA personally and believed she was a good person. V4 stated she informed the Director of Nursing only about phone use and did not report the allegation of rough care. V4 acknowledged that abuse allegations are to be reported immediately but stated uncertainty regarding who the Administrator was at the time.On 01/20/26 at 2:45 p.m., R3 stated he reported (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident so other residents would not receive rushed or rough care. R3 stated he did not believe the CNA intentionally abused him but felt her distraction caused rough care.On 01/20/26 at 3:25 p.m., R3 further stated the CNA belittled him on the phone, calling him lazy and stating he did not need help. R3 reported he informed nursing and therapy staff.On 01/20/26 at 3:40 p.m., V16, Licensed Practical Nurse (LPN), confirmed R3 reported the CNA was on the phone, belittling him, and rough with care. V16 stated she immediately informed the Director of Nursing.On 01/20/26 at 4:35 p.m., V1, Interim Administrator/Abuse Prevention Coordinator, and V2, Director of Nursing, stated they were not aware of R3's grievance.On 01/21/26, facility leadership confirmed the allegation was not reported or investigated as potential abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to recognize and report allegations of abuse to the administrator for two (R1, R3) of three residents reviewed for abuse on the sample list of 15.Findings include: 1.R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status score as nine out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R1 has limited range of motion of the bilateral upper extremities. The MDS further documents R1 is totally dependent for all activities of daily living except eating. R1 requires substantial to maximum assistance with toileting, has not ambulated during the look-back period, and uses a manual wheelchair requiring partial to moderate assistance once seated. R1 has had no behaviors toward self or others and no rejection of care.On 01/16/26 at 2:40 p.m., R1 was lying on her back in bed. R1 stated, The girl with the ponytail (later identified as V8, Certified Nursing Assistant) is the one who did this to me. At least that is the first time I saw these bruises. She is (specified race) and works in the morning. R1 raised both of her sleeves, revealing bruises to the posterior mid-forearms. R1's left forearm had a quarter-sized purple bruise surrounded by a yellow halo-like faded area, indicative of older bruising. On the right forearm, R1 had a nickel-sized bruise that was purple in the center and surrounded by yellow halo-like fading, also indicative of older bruising.R1 then grabbed her right neck area and stated, She also hurt my neck when she was transferring me. It's when she is giving me care-she hurts me. It kind of choked me up. She grabbed behind my neck to set me up to transfer, and it made me cough. I'm scared she might do it again. I didn't say anything to her. I should have. She has helped me many times before, and that did not happen. She was here today, this morning. That girl (V8, CNA) with the ponytail is rough, and I should tell her to slow down or be more careful when she gives me care. Other than that, I feel she is a good CNA. She needs to provide my care slower and gentler. I think she's always in a hurry. I am really scared since the other day when that happened. When she comes in here, I know she could hurt me. She hasn't any other time, but it could happen again.R1 also stated, I told the lady up in the front offices (later identified as V4, Social Service Director). She's the one who noticed my arm bruises. I told her all about that girl being rough with me. She's a very nice (specified race) lady. She's young and has an office up in the front hall. I don't know her name. Nobody ever came in and talked to me about it, but she told me she was going to report it to her boss. I thought someone would be asking me questions. Nobody has. I trusted that lady would do something about that girl.On 01/16/26 at 2:50 p.m., this surveyor reported the allegation details of rough care, physical abuse, and arm bruising reported by R1 to V2, Director of Nursing, and V3, Regional Nurse Consultant. V3 contacted V1, Interim Administrator/Abuse Prevention Coordinator/Vice President of Operations, for a conference call. V1, V2, and V3 all stated they were not aware of any allegations of abuse that had been reported, including the allegation regarding R1.The facility's January Concern Log - Year 2026 documents a grievance dated 01/14/26 as follows: Night Shift, Unit 1. Concern reported by Patient (R1). Name: Social Service Director (V4) / Business Office Manager (V18). Concern Type: Care-Staff Approach. Patient Name and Brief Description: (R1) wants to discharge home; stated she is tired of the mean CNA that works nights. She stated the CNA is rough with care. Concern Assigned to: Administrator (V1, Interim Administrator/Abuse Prevention Coordinator). Resolution Communication Method: Employee - Written Notice. Date Resolved: 01/14/26 (same day the grievance was reported).On 01/20/26 at 1:30 p.m., V4, Social Service Director (SSD), reviewed the grievance log and confirmed she received and recorded a grievance on 01/14/26 regarding R1's allegation that V8, Certified Nursing Assistant, was rough with care, caused (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruising to R1's bilateral forearms, and caused neck pain. V4 stated she reported the allegation of abuse to V1, Interim Administrator/Abuse Prevention Coordinator. As noted above, V1, V2, and V3 all stated this allegation was not reported to them.On 01/22/26 at 3:42 p.m., V8, Certified Nursing Assistant, stated she was suspended on 01/16/26, two days after the grievance dated 01/14/26 regarding the physical abuse allegation involving R1.On 01/27/26 at 10:30 a.m., V7, Local County Community Support Services Manager, confirmed she was present on 01/14/26 with R1 and V4. V7 stated R1 described a CNA with a ponytail who was rough when getting her up that morning. V7 stated R1 had small bruises on both forearms that appeared faded and that R1 was unsure how they occurred but associated them with being transferred out of bed to a standing position. V7 further stated R1 reported feeling a pull to her neck during the transfer. V7 stated R1 had been hospitalized approximately one week earlier for chest and neck pain and that this information was included in her complaint to ensure investigation. V7 stated R1 was afraid the CNA would be rough with her care again. Although R1 was not tearful, she was upset about therapy and expressed fear regarding the CNA's care. V4 acknowledged R1's incident of rough care and stated it would be reported to the Administrator and investigated as possible abuse.2. R3's current Diagnoses sheet documents: Other Specified Postprocedural Status; Aftercare Following Joint Replacement Surgery.R3's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment.The facility's January Concern Log - Year 2026 documents a grievance dated 01/07/26 as follows: Night Shift, Unit 1. Concern reported by Patient (R3). Name: Social Service Director (V4). Concern Type: Care-Staff Approach. Patient Name and Brief Description: (R3), CNA on phone during care. Concern Assigned to: Social Service. Resolution Communication Method: Employee - Written Notice. Date Resolved: 01/07/26 (same day reported).On 01/20/26 at 1:55 p.m., V4 reviewed the grievance log and R3's grievance. V4 stated R3 reported the CNA was on her phone while providing care, was rude, and was rough with care. V4 identified the CNA as V11. V4 stated she contacted V11 on her personal cell phone and addressed the phone use. V4 stated she did not consider the situation abuse because she knew the CNA personally and believed she was a good person. V4 stated she informed the Director of Nursing only about phone use and did not report the allegation of rough care. V4 acknowledged abuse allegations are required to be reported immediately but stated uncertainty regarding who the Administrator was at the time.On 01/20/26 at 2:45 p.m., R3 was seated in his wheelchair at the bedside with his left arm in a sling. R3 stated he reported the incident on 01/07/26 to V4 because the CNA was on her phone the entire time she was providing care, appeared rushed, and was rough. R3 stated he reported the incident to prevent other residents from receiving rushed or rough care. R3 stated he did not believe the CNA intentionally abused him but felt her distraction resulted in rough care. R3 stated he was afraid other residents would receive rough care.On 01/20/26 at 3:25 p.m., R3 stated the CNA belittled him while on the phone, stating he was lazy and did not need the help she was providing. R3 stated he reported this to V16, Licensed Practical Nurse, and to therapy staff.On 01/20/26 at 3:40 p.m., V16, Licensed Practical Nurse (LPN), confirmed she was aware of R3's allegations of verbal and physical abuse but did not report them to the Administrator because she was unsure who the Interim Administrator was at the time.On 01/20/26 at 4:35 p.m., V1, Interim Administrator/Abuse Prevention Coordinator, and V2, Director of Nursing, stated they were not aware of R3's grievance reported to V4.On 01/21/26 at 9:45 a.m., V2 stated she was not informed of allegations involving rough or belittling care and stated such allegations should have been reported immediately as possible abuse and investigated.On 01/21/26 at 11:20 a.m., V14, Physical Therapy Assistant (PTA), confirmed she was aware of R3's allegations of verbal and physical abuse and had escorted R3 to V4's office to report them but did not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report the allegations to the Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review multiple facility staff had knowledge of allegations of rough care and derogatory comments, failed to report to the Administrator/Abuse Prevention Coordinator which resulted in a delay in initiating an investigation and failure to remove the alleged staff perpetrators. This failure had the potential to affect two of three residents (R1 and R3) reviewed for abuse on the sample list of 15.Findings include:1. R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status score as nine out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R1 has limited range of motion of the bilateral upper extremities and is totally dependent for all activities of daily living except eating. R1 requires substantial to maximum assistance with toileting, has not ambulated during the look-back period, and uses a manual wheelchair requiring partial to moderate assistance once seated. The MDS further documents R1 has had no behaviors toward self or others and no rejection of care.On 1/16/26 at 2:40 p.m., R1 was lying on her back in bed. R1 stated, The girl with the ponytail (later identified as V8, Certified Nursing Assistant) is the one who did this to me. At least that is the first time I saw these (bruises). She is (specified race) and works in the morning. R1 raised both arm sleeves. Both posterior mid-forearms had bruising. R1's left forearm had a quarter-sized purple bruise surrounded by a yellow halo-like faded bruise, indicative of older bruising. On the right forearm, R1 had a nickel-sized bruise with a purple center surrounded by yellow halo-like fading, also indicative of older bruising.R1 then grabbed her right neck area and stated, She also hurt my neck when she was transferring me. It's when she is giving me care that she hurts me. It kind of choked me up. She grabbed behind my neck to set me up to transfer. It made me cough. I'm scared she might do it again. I did not say anything to her. I should have. She has helped me many times before and that did not happen. She was here today, this morning. That girl (V8, CNA) with a ponytail is rough, and I should tell her to slow down or be careful when she gives me care. Other than that, I feel she is a good CNA. She needs to provide my care slower and gentler. I think she's always in a hurry. I am really scared since the other day when that happened. When she comes in here, I know she could hurt me. She hasn't any other time, but it could happen again.R1 also stated, I told the lady up in the front offices (later identified as V4, Social Service Director). She's the one that noticed my arm bruises. I told her all about that girl and being rough with me. She's a very nice (specified race) lady. She's young and has an office up in the front hall. I don't know her name. Nobody ever came in and talked to me about it, but she told me she was going to report it to her boss. I thought someone would be asking me questions. Nobody has. I trusted that lady would do something about that girl.On 1/16/26 at 2:50 p.m., this surveyor reported the allegation details of rough care/physical abuse and arm bruises R1 reported to this surveyor. The allegation was reported to V2, Director of Nursing, and V3, Regional Nurse Consultant, who contacted V1, Interim Administrator/Abuse Prevention Coordinator/Vice President of Operations, for a conference call. V1, V2, and V3 all stated they had no reported allegations of abuse, including the allegation regarding R1.The facility's January Concern Log Year 2026 documents a grievance dated 01/14/26 as follows: Night Shift, Unit 1. Concern reported by patient (R1). Name: Social Service Director (V4)/Business Office Manager (V18). Concern Type: Care-Staff Approach. Patient Name and Brief Description: (R1) wants to discharge home; stated she is tired of the mean CNA that works nights. She stated the CNA is rough with care. Concern Assigned To: Administrator (V1, Interim Administrator/Abuse Prevention Coordinator). Resolution Communication Method: Employee-Written Notice. Date Resolved: 01/14/26.On 1/20/26 at 1:30 p.m., V4, Social Service Director (SSD), reviewed the grievance log and confirmed she received and recorded a grievance on 1/14/26 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding R1's allegation that V8, Certified Nursing Assistant, was rough with care, caused bruising to bilateral forearms, and caused neck pain. V4 stated she reported the allegation to V1, Interim Administrator/Abuse Prevention Coordinator. As noted above, V1, V2, and V3 all stated this allegation was not reported to them.On 1/22/26 at 3:42 p.m., V8, Certified Nursing Assistant, stated she was suspended on 1/16/26, two days after the grievance dated 1/14/26 was reported to V4.V8's timecard documents that on 1/15/26, V8 worked eight and one-half hours after the grievance of abuse was reported.On 1/27/26 at 10:30 a.m., V7, Local County Community Support Service Manager, confirmed she was present on 1/14/26 with R1 and V4, Social Service Director. V7 stated R1 described a CNA with a ponytail who was rough when getting her up that morning. V7 stated, R1 had a small bruise on both forearms that appeared faded. R1 was not sure how they occurred but associated them with being transferred out of bed to a standing position. V7 also stated, R1 felt a pull to her neck as she stood during that transfer. I know she had gone to the hospital a week or so before for chest and neck pain. I included this in my complaint to make sure it was investigated. I don't know if it had anything to do with rough care.V7 further stated, R1 said she was afraid that CNA would be rough with her care again. Although R1 was not tearful, she was upset about therapy and said she was afraid of the CNA's care. The Social Service Director acknowledged R1's incident of rough care and said it would be reported to the Administrator and investigated as possible abuse.2. R3's current Diagnoses sheet documents the following: Other Specified Postprocedural Status, Aftercare Following Joint Replacement Surgery.R3's Minimum data Set (MDS) dated [DATE] documents the following: R3's Brief Interview of Mental Status score as 15, out of a possible 15, indicating no cognitive impairment.The facility January Concern Log Year 2026 documents a grievance dated 01/07/25 as follows: Night Shift, Unit 1. Concern Reported by Patient (R3). Name: Social Service Director (V4, SSD). Concern Type; Care-Staff Approach. Patient Name and Brief Description: (R3's), CNA (V11, Certified Nursing Assistant) on Phone during care. Concern Assigned to: Social Service. Resolution Communication Method: Employee - Written Notice. Date Resolved: 01/07/26 (same day, as noted above that the concern was reported).On 1/20/26 at 1:55 pm V4, Social Service Director (SSD) reviewed the grievance log where V4, SSD had documented R3's grievance, noted above. The grievance was dated 01/07/26. V4, SSD stated (R3) came to me after he had breakfast. I was in here (office). He (R3) rolled in, and was like, 'I want to talk to you about something'. He said last night he had this CNA (V11, Certified Nursing Assistant), while she was supposed to be giving him care, she was rough with him and was talking to someone on the phone. He described her as (described race, height and color of dyed hair V11, CNA). I said to him (R3), you know what, they (staff) are not supposed to be on phones. He (R3) said she (V11) was rude to him and rough with his care because she (V11, CNA) was not paying attention to what she was supposed to be doing. He said she was talking to somebody else, and not him. The CNA still wasn't asking him (R3) questions and stuff like that. I told him all their attention should be on the residents, and not on their phone calls. So, I called (V19, Lead CNA and Scheduler). I asked her (V19) who was the CNA that worked last night. She let me know it was (V11, Certified Nursing Assistant/CNA). I know (V11, CNA) personally, she is a relative of mine. So, I went outside to the back parking lot, on my personal cell phone. I called her and I was yelling at her. I told her (V11, CNA) she should not be talking on her phone when she is giving resident care. That's not proper. That is totally disrespectful, and she knew it. This surveyor then asked V4, SSD though, she felt comfortable talking to V11, CNA, did she recognize the situation of rough care as possible abuse, and did she report to anyone when she came back into the building. V4, SSD stated I guess I did not think it was abuse because I know (V11, CNA). She is a good person. I did tell the DON (V2, Director of Nursing) there was an issue with a CNA (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being on the phone when giving care, but I took care of it. (the allegation of rough care). This surveyor reviewed another section of the same grievance log and asked if I could get a copy of the written notice the grievance log documents. V4, SSD stated The Employee -written notice documented on the grievance log, just means I filled out a grievance form, and it involved an employee. The same thing I did with (R1). It was not a warning to the employee. V4 also stated (V11, CNA) knows she should take care of these residents, like she would take care of our (V4 and V11) Grandma. I did not think of it as abuse. I felt it was just awful and disrespectful. (R3) did not think of it as abuse either. If it was someone I did not know, I guess, I probably would have reported (the allegation of abuse). I do know we are supposed to report abuse immediately to the Administrator, so it can be investigated. I am not sure if (V20, Previous, Interim Administrator/Abuse Prevention Coordinator) was still the Administrator (01/07/26, day of grievance). I don't think (V1, Current, Interim Administrator/Abuse prevention Coordinator) was here (working in the facility) yet.On 1/20/26 at 2:45 pm R3 was seated in his wheelchair bedside. R3 had a sling on his left arm. R3 stated I reported on 01/07/26, to (V4, Social Service Director). I reported that the CNA (V11) was on her phone the whole time she was taking care of me. She was rushed and was rough with care. I told (V4, Social Service Director) so that, other residents, that CNA (V11) takes care of, wouldn't get rushed, rough care. There are other residents in worse shape than me. I feel like I am looking out for other residents, not just myself.On 1/20/26 at 3:25 pm R3 stated I remembered something else I forgot to tell you. I was thinking about everything I told (V4, SSD). When that CNA was on the phone, she was belittling me, to whoever she was talking to. She said she was helping me get ready for bed, and I did not need all the help she had to give me. She told (said to) that person (on the phone), I (R3) was just lazy. I told (V16, Licensed Practical Nurse/LPN). She knows all about it. I also told her and a therapy girl (later identified as V14, Physical Therapy Assistant) too.On 1/20/26 at 3:40 pm V16, Licensed Practical Nurse (LPN) stated Regarding (R3), actually, I had gone into his (R3's) room. He was working with a new therapist. I think her name is (later identified as V14, Physical Therapy Assistant/PTA). I'm not very familiar with her. He (R3) reported to the therapy staff (V14, PTA) and me that a CNA (Certified Nursing Assistant) named (V11, Certified Nursing Assistant), the night before, was on the phone belittling him. He said he had just told the therapy girl (V14, PTA) that when (V11, CNA) provided his care she was rough. He said she was calling him lazy and said he couldn't do anything for himself. She (V11, CNA) had to do everything for him. He is one of my favorites. When he told me that I wanted to cry right then. He is such a kind person. V16, LPN also stated I told the DON (V2, Director of Nursing) about it right after he (R3) told me. I left his room and went straight to (V2) DON. I think (R3) had already reported all this to (V4, Social Service Director). I know I am supposed to report to the Administrator, too. I did not know who the administrator was. I am still not sure if we have an Administrator (V1, Interim Administrator/Abuse Prevention Coordinator/ [NAME] President of Operations).On 1/20/26 at 4:35 pm V1, Interim Administrator/Abuse prevention Coordinator and V2, Director of Nursing said they were not aware of (R3's) grievance reported to V4, Social Service Director.On 1/21/26 at 9:45 am V2, Director of Nursing stated she was not aware of an allegation on 01/07/26 of R3 receiving rough care. V2 DON stated That should have been reported immediately, as an allegation of abuse, to the Administrator. I should have been given all the information. That could be abuse, or very poor nursing care. We would have to investigate this to be sure. It was not reported to me at all. We don't have that investigation.V11's Timecard documents V11 worked the following hours, after the incident occurred on 01/6/26 and was reported on 1/7/26 after breakfast:On 1/07/26, V11 worked for 11 hours and 15 minutes.On 1/08/26, V11 worked for seven hours.On 1/09/26, V11 worked for (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16 hours.On 1/12/26, V11 worked for seven and a half hours.On 1/13/26, V11 worked for eight hours.On 1/14/26, V11 worked for seven hours and forty-five minutes.On 1/15/26, V11 worked for eight hours.On 1/16/26, V11 worked for seven hours and forty-five minutes.On 1/17/26, V11 worked for eight hours.On 1/18/26 V11 worked for eight hours.On 1/19/26 V11 worked for eight hours.On 2/3/26 at 9:15 am V11, Certified Nursing Assistant, stated That was a long time ago (1/07/26) when (R3) said something to my sister (V4, Social Service Director) about me being on the phone. I don't remember anything about him (R3) saying anything about giving him rough care. My sister called me and told me he complained about me being on the phone during his care. I was on the phone with (V23, CNA). She works down that hall more often. That was the first time I took care of him. He said he did not want a (disposable incontinence brief) on. I called her to find out if he was supposed to wear one. I have never left a (disposable incontinence brief) off a resident, when I put them to bed, if they usually wear one. I did not say anything about him doing anything for himself. I had given him a shower earlier that evening, before dinner. It was about 4:00 pm. It was about 7:30 pm when I was helping him get ready for bed. I had put the sling on him after the shower and took it off after I transferred him to bed. He did not say anything like I was rough with him. He is easy to take care of. He is not a (require a mechanical full or stand lift), so I could do (transfer) him (R3) by myself. He never even said ouch during my care. V11, Certified Nursing Assistant confirmed that her timecard documents V11, CNA has worked ten shifts since 01/07/26, the evening of the allegation. V11 then stated she works all halls and has had full access to all residents each time she worked. V11 stated she was not suspended after V4,SSD talked to V11. V11 stated she was suspended on 01/21/26, after the allegation was reported by this surveyor, as an allegation of physical and mental abuse to the V1, Interim Administrator/Abuse Prevention Coordinator.On 2/03/26 at 12:30 pm, This surveyor and V1, Interim Administrator/Abuse Prevention Coordinator/ [NAME] President of Operations reviewed V11, CNA's timecard, the facility grievance log. V1 confirmed R3's allegations of rough care/physical abuse was reported on 1/07/26 to V4 Social Service Director, V14, Physical Therapy Assistant and V16, Licensed Practical Nurse but was not reported to V1. V1 acknowledged that V11, CNA continued to work throughout the facility for repeated shifts and should have been suspended at the time of the allegation was reported on 1/07/26.The facility policy Abuse, Neglect, Exploitation Policy dated as reviewed 01/23/26 and documents the following:Policy:It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Definitions:Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative. visitor or others but has not yet been investigated and, if verified. could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.Covered individual is anyone who is an owner, operator, employee, manager, agent or contractor of the facility. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s), and Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment, and Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.The same Abuse, Neglect, Exploitation Policy dated as reviewed 01/23/26 documents: VI. Protection of ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:A. Responding immediately to protect the alleged victim and integrity of the investigation.B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.C. Increased supervision of the alleged victim and residents.D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator.E. Protection from retaliation.F. Providing emotional support and counseling to the residents during and after the investigation, as needed.The same policy documents: VII. Reporting/ResponseA. The facility will have written procedures that include:I. Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.2. Assuring that reporters are free from retaliation or reprisal.3. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint.4. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a. Analyzing the occurrence(s} to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences.b. Defining how care provision will be changed and/or improved to protect residents receiving services:c. Training of staff on changes made and demonstration of staff competency after training is implemented.d. Identification of staff responsible for implementation of corrective actions.e. The expected date for implementation; andf. Identification of staff responsible for monitoring the implementation of the plan. The same policy Abuse, Neglect, Exploitation Policy dated as reviewed 01/23/26 documents: B. The Administrator will follow up with government agencies, during business hours. to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident. as required by state agencies.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement fall interventions to prevent injury for one of three residents (R10) reviewed for falls in the sample list of 15. These failures resulted in R10 sustaining a fall with a head laceration that required staple closure. Findings Include: The facility's Fall Prevention Program dated 2/2/26 documents the facility will assess each resident's fall risk and implement interventions to decrease residents' risk of falls and subsequent injuries.R10's Medical Diagnoses list dated January 2026 documents R10 is diagnosed with abnormalities of gait and mobility, lack of coordination, muscle weakness, and altered mental status.R10's Minimum Data Set (MDS) dated [DATE] documents R10 is moderately cognitively impaired and requires moderate staff assistance for transfers.R10's care plan dated 1/7/26 documents R10 is at risk for falls related to muscle weakness. Interventions included floor mats placed on the side of the bed, which were implemented on 1/6/26.R10's nurses' notes dated 1/25/26 document R10 was found on the floor in her room. V29, Registered Nurse (RN), documented R10 was lying on the floor on the right side of her bed in the fetal position. R10 stated she fell from the bed and that her head and neck hurt. R10 had blood on the right side of her head. Emergency Medical Services (EMS) was called, and R10 was sent to the emergency room for evaluation.R10's computed tomography (CT) results dated 1/25/26 document, R10 fell and sustained mild subcutaneous soft tissue swelling and a hematoma in the right posterior parietal region, as well as subcutaneous emphysema, which suggests sequelae from a laceration.R10's emergency room notes dated 1/25/26 document, R10 sustained a fall resulting in a head laceration requiring five staples.On 2/5/26 at 1:40 p.m., V29, Registered Nurse (RN), stated she was R10's nurse overnight on 1/24/26-1/25/26. V29 confirmed that at approximately 3:00 a.m. on 1/25/26, R10 fell from her bed to the floor. V29 stated R10 did not have fall floor mats in place on the side of the bed at the time of the fall. V29 confirmed R10 struck her head and sustained a right-sided laceration. V29 stated she sent R10 to the Emergency Department for evaluation.R10's progress notes dated 1/25/26 document, R10 returned to the facility with five staples to her head.On 2/5/26 at 2:45 p.m., V27, [NAME] President of Clinical Services, confirmed R10 had fall mats placed as a fall prevention intervention on 1/6/26 and that the mats should have been in place on the floor when R10 was in bed and at the time of the fall on 1/25/26. V27 confirmed fall mats help decrease the risk of injuries from falls and were a previously implemented intervention that should have been in place.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to administer multiple medications per physician order. This failure affected three of three residents (R13, R14, R15) reviewed for medication administration on the sample list of fifteen. Findings Include: The facility's Medication Error Policy dated 2/2/26 documents the facility shall ensure medications are administered according to physician orders. If medication errors occur, staff are to notify the physician, document the incident in the medical record, and report the incident to the appropriate supervisor.The Resident/Family Complaint Form dated 1/26/26 documents R13 filed a complaint stating she did not receive her evening medications on 1/23/26.On 2/5/26 at 11:48 a.m., V2, Director of Nursing (DON), stated residents on the Northeast Hall did not receive their evening medications on 1/23/26. V2 stated R13 filed a grievance regarding the incident. V2 stated she reviewed which residents missed their medications, identified the medications that were omitted, and reviewed the incident and any potential outcomes with V13, Medical Director.R13's Medication Administration Record (MAR) dated January 2026 documents the following medications were not administered on the evening of 1/23/26: Famotidine 20 milligrams (mg), Fluticasone Propionate nasal spray, Potassium Chloride 20 milliequivalents (mEq), Baclofen 10 mg, Diclofenac Sodium Gel 1%, and Gabapentin 1200 mg.R14's Medication Administration Record (MAR) dated January 2026 documents the following medications were not administered on the evening of 1/23/26: Atorvastatin 40 mg, Carvedilol 25 mg, Clonidine 0.1 mg, Doxazosin 4 mg, and Eliquis 2.5 mg.R15's Medication Administration Record (MAR) dated January 2026 documents the following medications were not administered on the evening of 1/23/26: Fluticasone Furoate inhalation 200-25 micrograms and Rosuvastatin 5 mg.On 2/5/26 at 11:48 a.m., V2, Director of Nursing (DON), confirmed nurses are required to administer medications per physician orders and to notify the physician and nurse supervisor when medications are not administered.